2006 Summary of Medical Benefits – Most Retirees Age 65 and Over

Plan Features	2006 Original Medicare Part A & B Known information as of 09/2005	2006 Secure Horizons (PacifiCare) Medicare Advantage *HMO - Plan 2A* Service area = all covered WA Secure Horizons zip codes	2006 Secure Horizons (PacifiCare) Medicare Advantage *PFFS – Plan 1* Service area = Offered nationwide	2006 Secure Horizons (PacifiCare) Medicare Advantage *PFFS – Plan 2A* Service area = Offered nationwide	2006 Group Health* Medicare Advantage HMO *Standard Plan* Service area = all covered WA Group Health zip codes	2006 Regence Medicare Supplement (closed to new enrollees in 1989) Services	Medicare Pays	Plan Pays	You Pay
Deductible Part B	$124	$0	$0	$0	$0	Part B Deduct	N/A	$0	$124
Out Of Pocket Limitations									
Out of Pocket Limitations	Varies dependent on service	$0	$0	$0	Limited to a maximum of $1,000 per member per calendar year	N/A	N/A	N/A	N/A
Hospitalization									
Semiprivate room and board, general nursing and other hospital services and supplies	First 60 days, all but $952 61st to 90th day, all but $238 a day, 91st to 150th day, all but $476 a day (see booklet regarding one time use of up to 60 reserve days). Beyond 150 days, $0 is paid. Psychiatric Inpatient Care has a 190-day lifetime maximum.	Payable at 100%, after $250 copay, per admission	1-90 days -$0 copay 91-150 days – $0 copay Beyond 150 days $0 is paid. Maximum benefit for a lifetime is 425 days.	$0 Per admission No maximum of days limit of coverage	$100 copayment per day up to a 3 day maximum, per member, per admission; no copayment on additional days thereafter.	First 60 days 61 – 90 days 91 – 150 days (60 day Lifetime Reserve Period) Over 365 days [1] Over 365 days	All but $952 All but $238 per day All but $476 per day $0 $0	$952 $238 per day $476 per day 90% $0	$0 $0 $0 10% 100%
Skilled Nursing Facility Care									
Semiprivate room and board, skilled nursing and rehabilitation services and other services and supplies	First 20 days, 100% of approved amount. Additional 80 days, all but $114 a day. Beyond 100 days, $0 is paid.	$0 days 1-20, $50/days 21-100. Limit 100 days per benefit period as defined by Medicare.	$0 days 1-100, days 101+ members responsibility.	$0 days 1-100, days 101+ members responsibility.	Covered up to 100 days per year, subject to Medicare guidelines and GHC approval. Must be in Medicare Certified facility	First 20 days 21st through 100th day No coverage after 100 days	All approved amounts All but $114 per day	$0 $114	$0 $0

*Group Health advises transplants are only covered when Medicare Guidelines are met.

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Physician									
Physician care in hospital, home, office and most outpatient ancillary services	80% of approved amount subject to $124 deductible	100% after $10 copay – PCP//$20 Specialist copay per visit	100% ($0 copay)	100% after $10 copay – PCP//$10 Specialist copay per visit	In hospital visits covered at 100%. Outpatient visits covered in full after $15 copay per visit	$124 (Part B Deductible)	$0	$0	$124
						Remainder of Medicare-approved amounts	80%	20%	$0
Well Care									
Routine Physical Exams	"Welcome to Medicare" One time only, within first 6 months of enrolling in Part B. 80% of approved amount, subject to $124 deductible.	100% after $10 copay – PCP//$20 Specialist copay per visit	$0 Initial Medicare routine physical	$0 Initial Medicare routine physical	$15 copay (when in accordance with GHC Well Adult & Well child Schedule).	Medicare Part B Deductible	$0	$0	$124
						Remainder of Medicare-approved amounts	80%	0%	20%
Routine Mammography	80% of approved amount	Payable at 100%.	Payable at 100%.	Payable at 100%.	$15 copay	Once during a calendar year	80% of the Medicare-approved amount	20% of the remaining usual and customary charges allowed by Medicare	0%

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Pap Smears	80% of approved amount	100% after $10 copay – Primary, 100% after $20 copay - Specialist	$0	$0	$15 copay	Once during a calendar year	Once during a calendar year	Any 20% of the remaining usual and customary charges allowed by Medicare	0%
Mental Health									
Mental Health—Inpatient and Outpatient	Inpatient – Same deductible & co-payments as shown under Hospitalization. Outpatient - 50% of approved amount for most outpatient mental health services, subject to $124 deductible	Outpatient: Payable at 100% after $20 copay per visit Inpatient: 100% after $250 copay, per admission to 190 days Lifetime Maximum.	Inpatient - $0 copay 190 days Lifetime Maximum. Outpatient – $0 copay	Inpatient - $0 per admit 190 days Lifetime Maximum. Outpatient - $10 copay	Outpatient services covered subject to Medicare guidelines and after a $15 copay (Authorization required)	Inpatient Outpatient	80% 80%	20% 20%	0% Subscriber pays any charges over special psychiatric allowance not paid by Medicare

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	Psychiatric inpatient hospital care has a 190 day lifetime maximum	All referrals come through the Primary Care Physician (PCP)			Inpatient services covered subject to Medicare guidelines 190 day lifetime limit. $100 copay to $300 per admit. GHC authorization required.	Inpatient services limited to Medicare guidelines & 190 day lifetime limit			
Home Health Care									
Part-time or intermittent skilled care or home health aide services	100% of approved amount for most services.	Covered for Medicare-certified skilled care per Medicare guidelines	Covered in full	Covered in full	Covered for Medicare-certified skilled care through GHC Home Health Services, according to Medicare guidelines	Medically necessary skilled care visits Medical supplies	100% 80%	0% 20%	0% 0%
Durable medical equipment and supplies	Varies dependent upon service.	Covered in full in accordance with Medicare guidelines	$0 copay	$0 copay	Covered according to Medicare guidelines	First $124 of Medicare-approved amounts	$0	$0	$124
						Remainder of Medicare-approved amounts	80%	20%	$0
Rehabilitation – Speech, Physical And Occupational Therapy									
Inpatient and outpatient services	80% for inpatient and outpatient services	Inpatient Services covered in full. Outpatient services covered subject to $20 copay per visit.	$0 copay	$10 copay	Inpatient Services – subject to $100 copay to a 3 day max, per admission. Outpatient services - covered subject to a $15 copay per visit.	Inpatient & Outpatient Services	80%%	20%	$0
Prescription Drugs									

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Note: Medicare Part D becomes effective January 1, 2006. Respondents quoted Plan D or better. Regence PPO plan is in various stages of being approved by CMS.	Retiree selects a prescription Part D plan from a vendor, and pays a premium for the plan selected. To learn more about prescriptions plans available in your area, retiree can visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048.	**Retail:** 100% after $10 copay for formulary generic, 100% after $20 copay for formulary brand, 100% after $20 copay for non-formulary with provider authorization. 30-day supply or one (1) Prescription Unit. **Mail Order:** 2 copays for 90-day supply.	**Retail:** 100% after $10 copay for formulary generic, 100% after $20 copay for formulary brand, 100% after $20 copay for non-formulary with provider authorization. 30-day supply or one (1) Prescription Unit. **Mail Order:** 2 copays for 90-day supply.	**Retail:** 100% after $10 copay for formulary generic, 100% after $20 copay for formulary brand, 100% after $20 copay for non-formulary with provider authorization. 30-day supply or one (1) Prescription Unit. **Mail Order:** 2 copays for 90-day supply.	$15 generic copay/ $30 brand copay per 30-day supply for prescription or refill. Some exclusions apply.	**Current Plan** - does not have prescription coverage. **2006 –** Opportunity to purchase Part D prescription coverage Subscriber pays - $250 deductible Subscriber pays - $5 for generics/$18 for formulary brand name/$35 for Non-formulary brand name. 25% specialty medications and those administered in LTC facility. Plan pays - 0% $2,251 to $5,100 Plan pays - 95% after $5,100			
Vision Care									
Exams	Not covered	100% after $10 copay, through Vision Service Plan (VSP)– PCP//$20 Specialist copay per visit	Not Covered	Not Covered	Paid in full after $15 copay once every 12 months	One Eye Exam per year	0%	100%	0%
Eyeglass Lenses & Frames	Not covered, with the exception of one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.	Not covered; Discounts available through Vision Service Plan providers (VSP).	Not Covered	Not Covered	Standard lenses (including contact lenses) covered in full once every 24 months. One pair eyeglasses or contact lenses immediately following cataract surgery performed at GHC. Frames covered up to $100 once every 24 months.	Not Covered		Not Covered	
Contact Lens Examination & Lenses		See above	Not Covered	Not Covered	Paid in full once every 24 months in lieu of eyeglass benefit	Not Covered		Not Covered	
Hearing Exams And Hearing Aids									
Exams	Routine Hearing Exam - Not covered	$10 copay – PCP/$20 Specialist copay per visit	Not Covered	Not Covered	Covered in full after $15 copay per visit	One Exam Per calendar year.	0%	100%`	0%

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Hearing Aids	Not covered	$300 allowance every 2 years	Not Covered	Not Covered	Covered up to $250, once every 24 months (hearing aid must be purchased through GHC)	Not Covered		Not Covered	